Correspondence

Dietl's Crisis Revisited—The Enigma of Nephroptosis

TO THE EDITOR: I would like to report a new twist on an old condition. I am a 32-year-old female physician who is athletic and thin. In January 1993 I began having intermittent abdominal pain that radiated to my back and groin. This was accompanied by a protruding mass on my right side adjacent to the lateral rectus muscle. I went to a surgeon who diagnosed a spigelian hernia. This quarter-sized defect was repaired without difficulty using mesh. After the procedure, I still had a painful mass protruding into the area of repair that was mobile in a vertical plane of about 12 cm. I then went back for a laparoscopic evaluation, but no abnormal masses were seen. After an ultrasonogram, computed tomographic (CT) scan, and intravenous pyelogram, we realized that my kidney was the culprit. The inferior pole was pushing against my abdomen where it had previously herniated. It was highly mobile and at times rotated by 90 degrees on its axis. The CT scan revealed hydronephrosis of my right ureter when lying prone. In an effort to avoid another operation and to get some relief from the pain, I learned how to manipulate the kidney by pushing it up and posteriorly, trying to hold it under my ribs. Between seeing patients, I would lie supine on the floor. When I stood up, my blood pressure would go from 90/60 to 150/90 mm of mercury. Eventually, I had the aberration fixed and have not had problems since.

The results of a literature search left me disillusioned; this condition, once known as Dietl's crisis and which mostly affects women, had been greatly misunderstood.[1] Some surgeons operated on asymptomatic ptotic kidneys in women who actually had other causes of pain.[2] The surgical techniques used in the past were also known to cause complications,[2,3] which led to the idea that repair was futile. McWhinnie and Hamilton took this idea further by concluding that "The predominance of female patients might suggest that this syndrome was the early equivalent of later forms of nonorganic pain," and that "like other ineffective treatments for imaginary disease, surgery for the movable kidney simply faded away."[4 (pp846,847)] As a result of earlier misfortunes of diagnosis and treatment, this anatomic variant, which occurs in 20% of women and 2% to 7% of men,[3,5] is not mentioned in our current texts.

Abnormal renal mobility should be investigated and treated when secondary complications or severe symptoms occur.[2,3,5,6] Information about this condition should be placed back into our kidney and urologic texts to help us diagnose and treat this common anatomic variant, which can cause real, not imaginary, symptoms.

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Can Specialists Practice Primary Care?

TO THE EDITOR: Michael Jacobs, MD, in his commentary in the January 1995 issue,[1] attempts to compartmentalize the services of specialists and generalists. But one needs to realize that their roles are the different facets of the same profession, with considerable overlap among their practices. I opted for a primary care year after my internal medicine residency, but then decided to achieve a certain degree of expertise in gastroenterology before beginning my primary care career. Does this mean I will not be a generalist first just because of my rendezvous with a specialty? I love primary care and intend to practice it despite my fellowship training. I see no reason why a generalist like me cannot, at times, be a specialist, too. It's what you practice from the start of your career that matters rather than all this primary care rhetoric that creates an artificial division among specialists and generalists. Retooling, retraining, and rethinking may not apply to the fresh breed of primary care specialists entering the market today.

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Dr Jacobs Responds

TO THE EDITOR: Yes, indeed, Dr Vasireddi is correct in stating that physicians' "roles are the different facets of the same profession," but no, that does not necessarily imply "considerable overlap among their practices." In fact, therein lies my concern.

For those specialists and subspecialists who have dedicated their professional lives to mastering a narrow discipline, switching to a generalist field, with its necessarily broad knowledge base and unique set of behaviors and skills, will undoubtedly lead to frustration. On the other hand, for the many practicing specialist physicians (especially gynecologists and certain internal medicine subspecialists) who already practice and enjoy generalist medicine, I have no problem whatsoever with having them counted in the ranks of primary care physicians.